STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155733	A. BUILDING 00 B. WING	04/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL NURSING HOME	119 N INDIANA AVE CROWN POINT, IN46307

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: April 11, 12, and 14, 2011 Facility number: 000360 Provider number: 155733 AIM number: 100290370 Survey team: Sheila Sizemore, RN, TC Kelly Sizemore, RN Marcia Mital, RN Regina Sanders, RN Census bed type: NF: 9 SNF/NF: 27 Total: 36 Census Payor type: Medicare: 7 Medicaid: 27 Other: 2 Total: 36 Sample: 10 Supplemental: 4 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000	**This plan of correction is to serve as Colonial Nursing Home's credible allegation of compliance.** **Submission of this plan of correction does not constitute an admission by Colonial Nursing Home or it's management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed on April 19, 2011 by Bev Faulkner, RN			
F0282	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			
SS=D	Based on observation, record review and interview, the facility failed to ensure physician's orders were followed, related to medications, a pressure ulcer intervention, and laboratory tests for 3 of 10 residents reviewed for following physician orders in a sample of 10. (Residents #10, #22, and #27) Findings include: 1. Resident #10's record was reviewed on 04/11/11 at 11:30 a.m. The Resident's diagnoses included, but were not limited to, hypothyroidism and cerebral palsy. A Physician's order, dated 07/19/10, indicated to recheck the residents TSH (thyroid stimulating hormone) and T4 (thyroxin) (laboratory tests of the thyroid) in six weeks, 08/30/10. There was a lack of documentation in the resident's record to indicate the resident's laboratory test had been completed on 08/30/10. During an interview on 04/12/11 at 8:25 a.m., the Assistant Director of Nursing indicated the laboratory test had not been completed. She indicated the lab company had not been notified of	F0282	**F282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS PER CARE PLAN** It is the practice of Colonial Nursing Home to provide services by qualified persons in accordance with each resident's written plan of care. I. Resident #22's heels are being off loaded when in bed to relieve pressure. Upon realizing that the lab tests for Resident #10 had not been completed, the physician was notified and the lab tests were done. Resident #27 had no adverse effects from receiving the antihypertensive medication. II. All residents have the potential to be affected. This is being addressed by the systems described below. III. The facility has a policy regarding following resident's care plans. Licensed nurses have been re-educated regarding this policy. A lab tracking tool has been implemented to track to ensure lab tests are being completed as ordered. Licensed nurses have been inserviced on this procedure. An additional inservice was conducted regarding the need to monitor the	05/14/2011

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	the order.		resident's blood pressure and administer the medication as ordered. Systemic changes are being monitored through our quality improvement program as indicated. IV. The Director of Nursing or her designee is conducting quality improvement audits of the resident's overall plan of care. A random sample of 3 residents are being checked weekly to ensure that labs are performed as ordered, that medications are given as prescribed including monitoring blood pressure, and that pressure ulcer prevention strategies are in place. These audits will continue weekly for 4 weeks; then every other week for 4 weeks; then monthly for 6 months. Results of all audits are being reported to the facility's QA Committee monthly for additional recommendations where necessary.	
SS=D	2. Resident #27's record was reviewed on 4/11/11 at 11:20 a.m. Resident #27's diagnoses included, but were not limited to, congestive heart failure, hypertension, and chronic obstructive pulmonary disease. A MAR (Medication Administration Record), dated 4/1/11, indicated Amlodipine Besylate (blood pressure medication) 2.5 mg (milligrams), give 1 tablet orally every morning (hold if SBP [systolic blood pressure] < (less than) 100). It was initialed as given on 4/6/11 at 9 a.m.		**F282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS PER CARE PLAN** It is the practice of Colonial Nursing Home to provide services by qualified persons in accordance with each resident's written plan of care. I. Resident #22's heels are being off loaded when in bed to relieve pressure. Upon realizing that the lab tests for Resident #10 had not been completed, the physician was notified and the lab tests were done. Resident #27 had no adverse effects from receiving the antihypertensive medication. II.	05/14/2011

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	A Blood Pressure Log, dated 4/2011, indicated on 4/6 the resident's blood pressure was 96/66. During an interview with the MDS Coordinator, on 4/12/11 at 9:05 a.m., she indicated the blood pressure medication should have been held because that was what the order says.		All residents have the potential to be affected. This is being addressed by the systems described below. III. The facility has a policy regarding following resident's care plans. Licensed nurses have been re-educated regarding this policy. A lab tracking tool has been implemented to track to ensure lab tests are being completed as ordered. Licensed nurses have been inserviced on this procedure. An additional inservice was conducted regarding the need to monitor the resident's blood pressure and administer the medication as ordered. Systemic changes are being monitored through our quality improvement program as indicated. IV. The Director of Nursing or her designee is conducting quality improvement audits of the resident's overall plan of care. A random sample of 3 residents are being checked weekly to ensure that labs are performed as ordered, that medications are given as prescribed including monitoring blood pressure, and that pressure ulcer prevention strategies are in place. These audits will continue weekly for 4 weeks; then every other week for 4 weeks; then monthly for 6 months. Results of all audits are being reported to the facility's QA Committee monthly for additional recommendations where necessary.	

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SS=D	3. Resident #22 was observed on 4/11/11 at 11:20 a.m., laying on her back in bed sleeping. The resident's heels were not floated off the mattress of the bed. Resident #22 was observed on 4/12/11 at 8:55 a.m., 9:42 a.m., and 10:00 a.m., in bed. The resident's heels were not floated off the mattress of the bed. Resident #22's record was reviewed on 4/11/11 at 11:30 a.m. Resident #22's diagnoses included, but were not limited to, cirrhosis of the liver, chronic renal failure, and congestive heart failure. A Resident Assessment Protocol Conclusion Report, dated 1/20/11, indicated Resident #22 was at risk for pressure ulcers due to her incontinence, diagnoses and decline in mobility. A physician's order, dated 2/3/11, indicated "Float heels while in bed." During an interview on 4/12/11 at 10:00 a.m., the Director of Nursing indicated the resident's heels were not floated off the mattress. 3.1-35(g)(2)	F0282	**F282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS PER CARE PLAN** It is the practice of Colonial Nursing Home to provide services by qualified persons in accordance with each resident's written plan of care. I. Resident #22's heels are being off loaded when in bed to relieve pressure. Upon realizing that the lab tests for Resident #10 had not been completed, the physician was notified and the lab tests were done. Resident #27 had no adverse effects from receiving the antihypertensive medication. II. All residents have the potential to be affected. This is being addressed by the systems described below. III. The facility has a policy regarding following resident's care plans. Licensed nurses have been re-educated regarding this policy. A lab tracking tool has been implemented to track to ensure lab tests are being completed as ordered. Licensed nurses have been inserviced on this procedure. An additional inservice was conducted regarding the need to monitor the resident's blood pressure and administer the medication as ordered. Systemic changes are being monitored through our quality improvement program as indicated. IV. The Director of Nursing or her designee is conducting quality improvement audits of the resident's overall plan of care. A random sample of	05/14/2011

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			3 residents are being checked weekly to ensure that labs are performed as ordered, that medications are given as prescribed including monitoring blood pressure, and that pressure ulcer prevention strategies are in place. These audits will continue weekly for 4 weeks; then every other week for 4 weeks; then monthly for 6 months. Results of all audits are being reported to the facility's QA Committee monthly for additional recommendations where necessary.	
F0309	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.			
SS=D	Based on observation, record review, and interview, the facility failed to ensure a resident with edema received the necessary care and services related to ace wraps (elastic wraps) not being applied as ordered for 1 resident in a sample of 10 residents reviewed for necessary care and services in a total sample of 10. (Resident #27)	F0309	**F309 483.25 PROVIDE CARE SERVICES FOR HIGHEST WELL BEING** It is the practice of Colonial Nursing Home to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. I. Resident #27 is receiving the ace wraps to legs as ordered. II. All residents have the potential to be affected. Residents with orders for ace wraps were reviewed to ensure the treatment is being applied. No concerns were noted. III. Licensed nurses were re-educated on the need to	05/14/2011

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	Findings include: Resident #27's record was reviewed on 4/11/11 at 11:20 a.m. Resident #27's diagnoses included, but were not limited to, CHF (congestive heart failure), and pneumonia. A nurses' note, dated 4/10/11 at 8 a.m., indicated "....B (bilateral) LE'S (lower extremities) 3+ edema (swelling) noted...ace wraps from toes to knees wrapped..." A care plan, dated 3/20/11, indicated "edema...assess amount of edema...ace wraps for compression to BLE (bilateral lower extremities) up (indicated by an arrow pointed up) to thigh. Apply in a.m. remove @ (at) 5 p & re-wrap		provide treatment as ordered, including ace wraps. Systemic changes are being monitored through our quality improvement program as indicated. IV. The Director of Nursing or her designee is conducting quality improvement audits to ensure care is provided as necessary. Quality of care rounds are being completed. A random sample of 5 residents will be audited to ensure that the necessary care is being provided weekly for 4 weeks; then every other week for 4 weeks; then monthly for 6 months. Results of all audits are being reported to the facility's QA Committee monthly for additional recommendations where necessary.	

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	remove @ 10 p.m." A physician's order, dated 4/5/11, indicated to apply ace wraps to both legs up to the thigh, apply in the morning and remove and re-wrap at 5 p.m., and to remove at 10 p.m. The Resident's treatment record, dated 4/11, indicated the ace wraps were to be applied at 9:00 a.m. Resident #27 was observed sitting up in his wheelchair with a sock on his right foot and a foam boot to his left leg on 4/11/11 at 11:18 a.m., 12:04 p.m., and 1:15 p.m. The resident's feet were swollen. The resident did not have ace wraps applied to his lower extremities.			

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	Resident #27 was observed on 4/11/11 at 1:28 p.m., being assisted to bed by CNA #1 and LPN #2. CNA #1 was observed removing the resident's sock from his right foot. The sock left indentations at the calf when removed. The CNA indicated the resident's sock had left a deep indentation into his leg. The resident's legs were swollen. During an interview on 4/11/11 at 1:40 a.m., LPN #3 who was taking care of resident #27, indicated she had not gotten to the treatment yet today. 3.1-37(a)			

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F0314	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.			
SS=D	Based on observation, record review, and interview, the facility failed to ensure preventative measures were in place to prevent pressure ulcers for 1 of 10 residents at risk for pressure ulcers and failed to ensure pressure reduction measures were in place for 1 of 3 residents with pressure ulcers in a sample of 10. (Residents #22 and #27) Findings include: 1. Resident #27's record was reviewed on 4/11/11 at 11:20	F0314	**F314 483.25(c) PRESSURE SORES** It is the practice of Colonial Nursing Home to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. I. Resident #27 has the foam boots in place to both feet and heels are off loaded when in bed to prevent further pressure. Resident #22's heels are being off loaded when in bed to relieve pressure. II. All residents have the potential to be affected. This is being addressed by the systems described below. III. The facility has a policy regarding pressure ulcer prevention. Nursing personnel were re-educated on this policy. The CNAs are completing skin	05/14/2011

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	a.m. Resident #27's diagnoses included, but were not limited to, CHF (congestive heart failure), and pneumonia. Resident #27 was observed sitting up in his wheelchair with a sock on his right foot and a foam boot to his left leg on 4/11/11 at 11:18 a.m., 12:04 p.m., and 1:15 p.m. The resident's admission MDS (Minimum Data Set) assessment, dated 3/4/11, indicated the resident's cognitive status was severely impaired. The resident required extensive assistance of one staff member for bed mobility and the resident had no pressure ulcers. A "Braden Pressure Ulcer Risk" assessment, dated		checks on shower days; the licensed nurses are documenting a weekly skin check to further assess for skin abnormalities. Systemic changes are being monitored through our quality improvement program as indicated. IV. The Director of Nursing or her designee is conducting quality improvement audits to ensure care is provided as necessary. Quality of care rounds are being completed. A random sample of 5 residents will be audited to ensure that the necessary care including pressure reduction measures is being provided weekly for 4 weeks; then every other week for 4 weeks; then monthly for 6 months. Results of all audits are being reported to the facility's QA Committee monthly for additional recommendations where necessary.	

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	2/28/11, indicated the resident had a total score of 18. The form indicated a score of 15-18 was at mild risk to develop pressure ulcers. A care plan, dated 3/1/11, indicated "At risk for impaired skin integrity r/t (related to) impaired physical mobility...Ensure that all ordered pressure relieving/reducing devices are in place...float heels (4/5/11)..." A physician's order, dated 4/5/11, indicated "...deep tissue injury L (left) heel)...wrap left heel QD (every day) c (with) kerlix...Podus boot (pressure relieving device) to L LE (lower extremity) @ (at) all X's (times)...float R (right) heel when in bed..."			

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	A "Weekly Wound Evaluation Flow Record", dated 4/5/11, indicated the resident had an unstagable pressure ulcer to his left heel, which measured 4 centimeters (cm) by 4 cm, which was necrotic (dead tissue) and the surrounding tissue was pink. A care plan, dated 4/5/11, indicated "Res (resident) has suspected deep tissue injury to L (left) heel...podus boot to LLE (left lower extremity) @ (at) all X's ...Float B (Bilateral) heels...when in bed...Foam boot to L heel @ all X's..." During an interview on 4/11/11 at 1:27 p.m., LPN #2 indicated the resident did not have a Podus boot on his left leg. She indicated the foam boot he was wearing was not the same as			

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	the podus boot he was wearing the other day when she worked. Resident #27 was observed on 4/11/11 at 1:28 p.m., being assisted to bed by CNA #1 and LPN #2. CNA #1 was observed removing the resident's sock from his swollen right foot. The sock left indentations at the calf when removed. There was a pressure ulcer noted to the resident's right heel. The resident had a Kerlix dressing wrapped around his left foot. LPN #2 indicated the resident had a new pressure ulcer to his right heel. A "Weekly Wound Evaluation Flow Record", dated 4/11/11, indicated the resident had an unstagable pressure ulcer to his right heel, which measured 2.4			

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	centimeters (cm) by 1.5 cm, which was brown in color and had a scab which measured 0.2 cm by 0.5 cm in the center. During an interview on 4/11/11 at 1:40 p.m., LPN #3 indicated the pressure ulcer was a new area. During an interview on 4/11/11 at 1:53 p.m., the MDS coordinator indicated they had changed the podus boot to the foam boot because of the edema the resident had in his leg. Resident #27 was observed on 4/12/11 at 8:56 a.m., lying in bed on his back. The resident's heels were not elevated nor where there any foam boots on the resident's feet.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident #27 was observed on 4/12/11 at 8:59 a.m., with LPN #2 present, lying on his back in the bed. LPN #2 indicated the resident's heels were not floated on a pillow and the foam boots were not in place. LPN #2 then applied the foam boots to both feet. During an interview on 4/12/11 at 9:05 a.m., the MDS Coordinator indicated she had gotten the order yesterday to change the podus boot to the foam boots. She indicated the resident was to have the foam boots on both feet at all times except for skin checks. Resident #27's left heel was observed on 9:22 a.m., with the MDS Coordinator, the MDS Coordinator indicated the resident's heel was a deep			

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	155733	A. BUILDING 00 B. WING	04/14/2011

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	tissue injury and measured 4 cm by 4 cm and was purple black in color with brown edges.			
SS=D	2. Resident #22 was observed on 4/11/11 at 11:20 a.m., laying on her back in bed sleeping. The resident's heels were not floated off the mattress of the bed. Resident #22 was observed on 4/12/11 at 8:55 a.m., 9:42 a.m., and 10:00 a.m., in bed. The resident's heels were not floated off the mattress of the bed. Resident #22's record was reviewed on 4/11/11 at 11:30 a.m. Resident #22's diagnoses included, but were not limited to, cirrhosis of the liver, chronic renal failure, and congestive heart failure. A Resident Assessment Protocol Conclusion Report, dated 1/20/11, indicated Resident #22 was at risk for pressure ulcers due to her incontinence, diagnoses and decline in mobility. A physician's order, dated 2/3/11, indicated "Float heels while in bed." During an interview on 4/12/11 at 10:00 a.m., the Director of Nursing indicated the resident's heels were not floated off the		**F314 483.25(c) PRESSURE SORES** It is the practice of Colonial Nursing Home to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. I. Resident #27 has the foam boots in place to both feet and heels are off loaded when in bed to prevent further pressure. Resident #22's heels are being off loaded when in bed to relieve pressure. II. All residents have the potential to be affected. This is being addressed by the systems described below. III. The facility has a policy regarding pressure ulcer prevention. Nursing personnel were re-educated on this policy. The CNAs are completing skin checks on shower days; the licensed nurses are documenting a weekly skin check to further assess for skin abnormalities. Systemic changes are being monitored through our quality improvement program as	05/14/2011

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	mattress. 3.1-40(a) 3.1-40(a)(2)		indicated. IV. The Director of Nursing or her designee is conducting quality improvement audits to ensure care is provided as necessary. Quality of care rounds are being completed. A random sample of 5 residents will be audited to ensure that the necessary care including pressure reduction measures is being provided weekly for 4 weeks; then every other week for 4 weeks; then monthly for 6 months. Results of all audits are being reported to the facility's QA Committee monthly for additional recommendations where necessary.	
F0328	The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.			
SS=D	Based on observation, record review, and interview, the facility failed to ensure oxygen was administered as ordered by the physician for 2 of 5 residents reviewed for oxygen in a sample of 10 residents. (Residents #13 and #27) Findings include: 1. During the initial tour on 04/11/11 at 9:40 a.m.	F0328	**F328 483.25(k) SPECIAL NEEDS** It is the practice of Colonial Nursing Home to ensure that residents receive proper treatment and care for special services. I. Resident #27 & #13 are receiving oxygen as ordered by the physician. II. Residents who utilize oxygen have been checked to ensure that the correct oxygen liter flow rate is on. III. Licensed nurses have been re-educated on the	05/14/2011

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	through 10:10 a.m., the Assistant Director of Nursing indicated Resident #13 had an order for oxygen at two liters continuously. During an observation of the resident at the time of the interview, the resident was laying in bed with his oxygen on. The rate of the oxygen concentrator was set at three liters. The Assistant Director of Nursing indicated at the time of the observation the oxygen was on at three liters and she then set the oxygen rate on the concentrator to two liters. Resident #13's record was reviewed on 04/12/11 at 2:50 p.m. The Resident's diagnoses were, but not limited to, stroke and dementia. The Resident's Physician's Recapitulation Orders, dated 04/11, indicated an order for oxygen at two liters per minute.		importance of following physician' s orders regarding oxygen therapy. The correct oxygen flow rate has been added to the resident's care plan and the treatment administration record. In addition the ordered oxygen flow rate is noted on the liquid portable tank as well as the in room concentrator. Nurses are checking the oxygen flow rate every shift to further ensure it is correct. IV. The Director of Nursing or her designee is conducting quality improvement audits to ensure care is provided as ordered. Quality of care rounds are being completed. A random sample of 5 residents will be audited to ensure that the necessary care including oxygen therapy is being provided as ordered weekly for 4 weeks; then every other week for 4 weeks; then monthly for 6 months. Results of all audits are being reported to the facility's QA Committee monthly for additional recommendations where necessary.	
SS=D	2. Resident #27 was observed on 4/11/11 at 11:18 a.m., 12:04 p.m., 12:08 p.m., 1:15 p.m., and 1:17 p.m., with his portable oxygen tank set on two liters. During an interview on 4/11/11 at 1:17 p.m., LPN #2 indicated the resident's portable oxygen tank should be set at four liters instead of two liters. LPN #2 was		**F328 483.25(k) SPECIAL NEEDS** It is the practice of Colonial Nursing Home to ensure that residents receive proper treatment and care for special services. I. Resident #27 & #13 are receiving oxygen as ordered by the physician. II. Residents who utilize oxygen have been checked to ensure that the correct oxygen liter flow rate is on. III. Licensed nurses have	05/14/2011

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	observed to take Resident #27's oxygen saturation level (amount of oxygen in the blood) which registered at 66% (Normal is 92 to 100%). LPN #2 was observed to turn the portable oxygen tank up to four liters. The resident's respirations were at 22 per minute. LPN #2 was observe to tell the resident to take deep breaths LPN #2 then was observed to measure the resident's oxygen saturation level at 1:24 p.m. The resident's oxygen saturation level was 90%. Resident #27's record was reviewed on 4/11/11 at 11:20 a.m. Resident #27's diagnoses included, but were not limited to, congestive heart failure, hypertension, and pneumonia. A physician's telephone order, dated 3/10/11 at 8:30 p.m., indicated "Increase (arrow pointing up) o2 (oxygen) n/c (nasal cannula) to 4 L (liters)." A care plan for impaired gas exchange, dated 3/1/11, indicated "...4 liters continuous 3/10/11...." A facility policy, dated 05/01, received as current from the Director of Nursing, titled, "Oxygen Safety", indicated, "...Oxygen therapy is administered to the resident only upon the written order..."		been re-educated on the importance of following physician' s orders regarding oxygen therapy. The correct oxygen flow rate has been added to the resident's care plan and the treatment administration record. In addition the ordered oxygen flow rate is noted on the liquid portable tank as well as the in room concentrator. Nurses are checking the oxygen flow rate every shift to further ensure it is correct. IV. The Director of Nursing or her designee is conducting quality improvement audits to ensure care is provided as ordered. Quality of care rounds are being completed. A random sample of 5 residents will be audited to ensure that the necessary care including oxygen therapy is being provided as ordered weekly for 4 weeks; then every other week for 4 weeks; then monthly for 6 months. Results of all audits are being reported to the facility's QA Committee monthly for additional recommendations where necessary.	

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	3.1-47(a)(6)			
F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to distribute and serve food under sanitary conditions related to, dirty cups, plates, plastic container and cutting board, for 1 of 1 Kitchen. This had the potential to affect 35 of 36 residents who consumed food prepared in the kitchen out of a total population of 36. Findings include: During the initial tour on 4/11/11 from 9:42 a.m. through 10:00 a.m., with the Dietary Manager, the following was observed: Kitchen: 1. There were three of three stored and ready to use cups, with food debris on the inside and outside of the cups.	F0371	**F371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY** It is the practice of Colonial Nursing Home to procure food from sources approved or considered satisfactory by Federal, State, or local authorities; and store, and prepare, distribute, and serve food under sanitary conditions. I. All cups soaked and re-washed All identified plates soaked and re-washed Food debris on plastic container cleaned Cutting board on bottom shelf cleaned, covered in plastic and moved to another location. II. All residents have the potential to be affected by deficient practice and the following corrective action has been taken. III. A daily and weekly cleaning schedule will be followed with a check off list initialed by responsible employee. Food	05/14/2011

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	2. There were 18 of 40 stored and ready to use plates with food particles on them. During an interview at the time of the observation, the Dietary Manager indicated she would rewash them. 3. The second shelf, next to the refrigerator, had a stored and ready to use plastic container that had food debris on it. 4. A cutting board stored and ready to use, on the bottom shelf next to the refrigerator, had food debris on it. 3.1-21(i)(1)		Service Supervisor and cooks will do daily checks of dishes and cups after all meals On April 14, 2011 Food Service Supervisor held an in-service with dietary staff, this in-service covered Sanitation, storage and proper cleaning of dishes, cups, cutting boards and all kitchen equipment. Food Service Supervisor is responsible for orientating any new hires on all aspects of dietary procedures. Dietary aides responsible for dish washing with cooks and/or Food Service Supv. spot checking for cleanliness on a daily basis. IV. Food Service Supervisor will be responsible for checking the entire kitchen daily for cleanliness. She will also check daily and weekly cleaning schedule to assure assignments are completed and disciplinary action taken for those failing to follow and/or document on forms. Forms will be maintained by Food Service Supervisor who reports progress to Administrator weekly and QA committee monthly on an ongoing basis.	
F0425	The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure			

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	the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.			
SS=D	Based on observation, interview, and record review, the facility failed to ensure expired medications were discarded related to 1 of 1 nasal spray, 1 of 5 bottles of eye drops, 1 of 6 bottles of cough syrup, and 1 of 7 bottles of polyethylene glycal powder (Miralax) (Laxative) for 2 of 2 medications carts. Findings include: 1. During an observation of the C-medication cart with LPN #2, on 04/12/11 at 9:05 a.m., there was an opened, non-dated container of Fluticasone nasal spray (allergy medication) with an expiration date of 10/10, an open bottle of polyethylene glycal powder with an expiration date of 04/10, and a bottle of robafen (cough syrup) with an expiration date of 11/10. During an interview at the time of the observation, LPN #2 indicated the medications were expired. She indicated all nurses are to check the medications and the Pharmacist comes and checks for	F0425	**F425 483.60(a)(b) PHARMACEUTICAL SVC, ACCURATE PROCEDURES, RPH** It is the practice of Colonial Nursing Home to provide routine and emergency drugs and biological to its residents; and to provide services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological) to meet the needs of each resident. I. The eye drops, cough medication, and laxative were disposed of and new medications were ordered. II. Medication carts were checked to ensure that there were no other out dated medications, or medications open beyond the acceptable date. No concerns were discovered. III. Licensed nurses were re-educated on the facility policy regarding expired medications and dating of medications when opened. Systemic changes are being monitored through our quality improvement program as indicated. IV. The Director of Nursing or her designee is conducting quality improvement audits of medications to check for expiration dates and open dates.	05/14/2011

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	expired medications every month.		A random sample of 5 residents medications are being checked weekly for 4 weeks; then 5 residents will be checked every other week for 4 weeks; then monthly for 6 months. The pharmacy consultant will assist in monitoring during monthly facility visits. Results of all audits are being reported to the facility's QA Committee monthly for additional recommendations where necessary	
SS=D	2. During an observation of a medication pass, on 4/12/11 at 3:45 p.m., LPN #4 took eye drops out of the medication cart. LPN #4 indicated she couldn't give the eye drops as ordered due to the eye drops were opened 3/5/11 and they are only good for 29 days after the eye drops are opened. A facility policy, titled "Expiration Dates and Compromised Medication", dated 6/17/08, indicated "...Eye drops, ear drops, insulin will expire 28 days after bottle opened..." 3.1-25(o)		**F425 483.60(a)(b) PHARMACEUTICAL SVC, ACCURATE PROCEDURES, RPH** It is the practice of Colonial Nursing Home to provide routine and emergency drugs and biological to its residents; and to provide services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological) to meet the needs of each resident. I. The eye drops, cough medication, and laxative were disposed of and new medications were ordered. II. Medication carts were checked to ensure that there were no other out dated medications, or medications open beyond the acceptable date. No concerns were discovered. III. Licensed nurses were re-educated on the facility policy regarding expired medications and dating of medications when opened. Systemic changes are being monitored through our quality improvement program as	05/14/2011

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			indicated. IV. The Director of Nursing or her designee is conducting quality improvement audits of medications to check for expiration dates and open dates. A random sample of 5 residents medications are being checked weekly for 4 weeks; then 5 residents will be checked every other week for 4 weeks; then monthly for 6 months. The pharmacy consultant will assist in monitoring during monthly facility visits. Results of all audits are being reported to the facility's QA Committee monthly for additional recommendations where necessary	
F0428	The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.			
SS=D	Based on record review and interview, the facility failed to ensure pharmacy recommendations were followed up on in a timely manner for 1 of 10 Residents reviewed for pharmacy recommendations in a sample of 10. (Resident #10) Findings include: Resident #10's record was reviewed on 04/11/11 at 11:30 a.m. The Resident's diagnoses included, but were not limited to, hypothyroidism and cerebral palsy.	F0428	**F428 483.60(c) DRUG REGIMEN REVIEW** It is the practice of Colonial Nursing Home to ensure that the drug regimen of each resident is reviewed at least monthly by the licensed pharmacist. I. The pharmacy recommendations on Resident #10 have been reviewed by the physician. II. All residents clinical records have been reviewed to ensure that there are no other pharmacy recommendations that have not been addressed by the physician.III. Licensed nurses were re-educated on the facility	05/14/2011

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	A Pharmacy, "Potential Drug Interaction" form, dated 03/16/11, indicated the resident was receiving levothyroxine (thyroid medication) 125 mcg (micrograms) and Calcium 500 mg (milligram) with vitamin D 200 I.U. (international units). The form indicated, "...The dosage of levothyroxine may need to be increased. Separating the administration times of levothyroxine and calcium carbonate may decrease the effects of the interaction...". The Pharmacy, "Potential Drug Interaction" form, dated 03/16/11, indicated, the resident was receiving levothyroxine 125 mcg and ferrous sulfate (iron) 220 mg/5 ml (milliliter). The form indicated, "...The administration times of thyroid agents and iron supplements should be separated by four hours..." The Pharmacy, "Potential Drug Interaction" form, dated 03/16/11, indicated, the resident was receiving Aspirin 81 mg and sertraline HCL (antidepressant) 100 mg. The form indicated, "...should be used concurrently with caution. Patients should be warned about the increased risk of bleeding..." The Pharmacy, "Potential Drug Interaction" form, dated 03/16/11, indicated the resident was receiving ferrous sulfate 220 mg/ 5 ml and calcium 500 mg with vitamin D 200 I.U. The form indicated, "...Iron supplements should not be taken within 1 hour before or 2 hours after calcium..." The Resident's Medication Administration Records, Dated 03/11 and 04/11, indicated the Resident's aspirin, calcium ferrous sulfate, levothyroxine, and sertraline HCL were all scheduled to be given at 6 a.m.		policy regarding pharmacy recommendations and the importance of timely follow through of the recommendation. Pharmacy has been requested to send the “Potential Drug Interaction” forms to a secure fax in the DON office. The DON or her designee will then facilitate the process by submitting the forms to the attending physician instead of placing them in clinical record for a more prompt response. IV. The Director of Nursing or her designee is conducting quality improvement audits of pharmacy recommendations to check for timely follow through. A random sample of 5 residents will be audited to ensure that the necessary recommended changes to the residents drug regimes is being provided as ordered weekly for 4 weeks; then every other week for 4 weeks; then monthly for 6 months. Results of all audits are being reported to the facility’s QA Committee monthly for additional recommendations where necessary.	

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	The Pharmacy, "Potential Drug Interaction" form, dated 03/16/11, indicated the form was faxed to the Physician on 03/21/11. The Resident's record indicated the last thyroid levels were completed on 07/19/10. During an interview on 04/11/11 at 1 p.m., the Assistant Director of Nursing (ADoN) indicated a Physician's orders was needed to change the time of the medications. She indicated the Physician had not responded to the fax sent about the medications on 03/21/11. During an interview on 04/12/11 at 11:45 a.m., the ADoN indicated the Physician had just sent the fax back and had ordered for the times of the medication to be changed. She indicated she usually follows up with the Physician the next day if the Physician had not responded to the pharmacy recommendations. During an interview on 04/12/11 at 11:45 a.m. , the Director of Nursing indicated a Physician's order is not needed to change the medications times if it is not ordered at a specific time. 3.1-25(i)			

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F0458	Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.			
SS=E	Based on observation, interview, and record review, the facility failed to provide the required square footage per resident in 1 of 5 single resident rooms and for 6 of 19 multiple resident rooms. The deficient practice had the potential to affect 4 of 4 residents in the six two person rooms and 1 of 1 resident in the one person room. (Rooms 101, 104, 111, 201, 202, 204, and 206) Findings include: Review of the facility layout pictures, received from the Administrator on 04/12/11 at 9 a.m., the following measurements of the rooms were: 1. The floor area of the following single resident room measured: *Room 111-1 resident, 96.2 SQ (square) FT (feet). NF.	F0458	**F 458 483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQUARE FT/RESIDENT** It is the practice of Colonial Nursing Home to provide bedrooms that measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident bedrooms. I. All affected rooms were measured and floor planned including furniture were completed for each room. II. All affected resident's conditions were reviewed for safety, comfort, nursing care delivery, and privacy to assure that there were no adverse effects to placement in rooms with square footage waivers. III. Prior to admission residents assessments will be reviewed to determine appropriate room assignment for potential residents. Residents will be assigned rooms by medical necessity and resident and family preference. IV. Residents conditions will be monitored by	05/14/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155733	A. BUILDING 00 B. WING	04/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL NURSING HOME	119 N INDIANA AVE CROWN POINT, IN46307

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	2. The floor areas of the following multiple resident rooms measured: *Room 101-2 residents, 150.3 SQ FT, 75.2 SQ FT per bed. NF *Room 104-2 residents, 145.0 SQ FT, 72.5 SQ FT per bed. NF *Room 201-no residents, 149.0 SQ FT, 74.5 SQ FT per bed. NF *Room 202-no residents, 144.0 SQ FT, 72.0 SQ FT per bed. NF *Room 204-no residents, 144.0 SQ FT, 72.0 SQ FT per bed. NF *Room 206-no residents, 140.0 SQ FT, 70.5 SQ FT per bed. NF The facility rooms with room variances were observed on 04/12/11 at 9 a.m. through 10 a.m. The rooms were observed to have the following amount of beds: Room 101-2 beds Room 104- 2 beds Room 111- 1 bed Room 201- 2 beds Room 202- 2 beds Room 204- 2 beds Room 206- 2 beds During a telephone interview on 04/13/11 at 10:45 a.m., the Administrator indicated room 101 had to be added to the room waivers due to a temporary move of a resident into the room, which resulted in		the Interdisciplinary Team during Care Plan Conferences for appropriateness of room assignment. The Team will make recommendations to the Administrator/designee of a potential difficulty with room assignment. The residents needs will be evaluated and if necessary a room change will be initiated. Social Service will discuss room transfers with the resident and/or responsible party to arrange for a smooth transition to a new room. The facility's QA Committee will assist as necessary.	

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	two beds in the room. She indicated the other room waivers had not changed. 3.1-19(l)(2)			